MONTANA MEDICAID CLAIM JUMPER

Volume VIII **The Montana Medicaid Newsletter** **JANUARY 2000**

New Consultec Provider Relations Manager

Consultec is pleased to announce that Sandie Hance is the new Consultec Provider Relations Manager effective January 1, 2000. Sandie joined the Montana Consultec fiscal agent account in 1984 and has spent most of her tenure acting as the Consultec Claims Manager. Sandie has a thorough understanding of Montana Medicaid policy, the Montana CHIP program, MMIS claims processing and the Montana provider community. Sandie has interacted with the Medicaid provider community on numerous occasions over the years. In her new capacity, she will be responsible for the Consultec Provider Relations Unit and all communication to the provider community. Consultec would like to ask the provider community to assist us in welcoming Sandie to her new position. If you need assistance of any kind, please feel free to contact the Montana Consultec Provider Relations Unit at 406-442-1837 for Helena & out-of-state providers and 1-800-624-3958 for in-state providers.

USUAL AND CUSTOMARY CHARGES

Usual and customary charges are those charges that the provider would normally charge for a service, regardless of payment methodology or insurer. Providers cannot bill Medicaid an amount more than they would charge other patients. Also, you must bill Medicaid for the same charges as you billed to Medicare.

All charges for services submitted to Medicaid must be made in accordance with an individual provider's USUAL AND CUSTOMARY charges to the general public unless:

1. A provider has entered into an agreement with the Department to provide services at a negotiated rate, or

2. A provider has been directed by the Department to submit charges at a Department specified rate.

PRIOR AUTHORIZATION MEANS BEFORE THE SERVICE

Many services reimbursed by Medicaid require prior authorization to be obtained. Some examples of these services are high-cost durable medical equipment, some dental procedures, non-emergency ambulance services, transportation, private duty nursing services, home and community based waiver services, selected mental health services, out-of-state inpatient hospital services, contact lenses, hearing aids, and selected prescription drugs.

Requests for authorizations should be made **before** the service or equipment is provided to the recipient. To help expedite the authorization process, make sure that you have included all necessary information as outlined in your provider manual.

PROVIDER SEMINAR LOCATIONS AND DATES ENCLOSED

Guidelines for When You Can and Cannot Bill a Medicaid Recipient

If a provider bills Medicaid for services rendered to the patient during an eligible period, that will be taken as an indication that the provider has accepted the patient as a Medicaid patient. **If an agreement is reached that Medicaid will be utilized, Medicaid payment must be accepted as payment in full.** Generally, providers are not allowed to seek payment from Montana Medicaid recipients other than for applicable co-payments. However, there are some exceptions to this rule.

Providers may limit the number of Medicaid patients in their practice. However, providers must advise recipients before accepting them as patients how they will be accepted for payment purposes, either as a Medicaid or as a private pay patient. If a recipient and provider cannot agree on the terms of their financial relationship, either party can sever that relationship. Providers must ensure they do not abandon a patient in a manner that could be considered a violation of professional ethics.

When a private-pay patient becomes retroactively eligible for Medicaid and is being treated by a provider who accepts Medicaid patients, the patient may ask that the provider bill prior services to Medicaid. **At the discretion of the provider**, the patient may be accepted as a Medicaid patient or be required to continue as a private pay patient if the patient wishes to continue being treated by that provider. The provider may accept the patient as a Medicaid patient from the date of the request forward, or go back as far as the date the recipient's retroactive Medicaid eligibility started. If the provider accepts the retroactive date and the patient has been billed and made full payment for services, the provider must refund the payment to the patient **before** billing Medicaid for those services. If the recipient has made partial payment, but not payment in full, the provider may either refund the payment to the recipient or show the payments as credits on claims submitted to Medicaid.

There are some services that are not covered by Medicaid. A provider may bill the recipient for these services only if the provider informed the recipient **in advance of providing the service** that Medicaid will not cover the specific service.

When emergency ambulance services are provided and the provider pursues reimbursement by Medicaid, the provider is required to submit the claim with documentation to Mountain Pacific Quality Health Foundation for medical review. If the services and determined medically necessary, the provider may then submit a claim to Consultec. If the Foundation determines that transport via ambulance was not medically necessary, the provider may bill the recipient.

A provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid for other covered services.

In service settings where the recipient is admitted or accepted as a Medicaid recipient by a provider, facility, or institution that arranges provision of ancillary providers, those ancillary providers will be deemed to have accepted the individual as a Medicaid patient and may not bill the recipient for the services unless, before the services were rendered, the particular provider informed the recipient of his or her refusal to accept Medicaid and the recipient agreed to pay for the services.

A provider may not bill a recipient for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, medical necessity reviews, billing or other requirements necessary to obtain payment.

Passport Authorization Procedures

PASSPORT TO HEALTH is a managed care program for Medicaid patients. It is based on the primary care case management model of managed care in which patients choose a PASSPORT primary care provider who acts as a "gatekeeper" for certain services. The patient must have those services provided by or authorized by the PASSPORT provider to be eligible for Medicaid payment. Please refer to your Montana Medicaid Provider Handbook and your service type's provider manuals for detailed information on which services require PASSPORT provider authorization.

Authorization is obtained by contacting the patient's PASSPORT provider **PRIOR** to services being performed. Attempting to get authorization after the service has been rendered is generally not acceptable and may serve to circumvent the intent of managed care.

The PASSPORT provider may provide written authorization, unless the PASSPORT provider waives written authorization and permits verbal authorization. If the referral is in writing, it should be kept on file by the provider as documentation. If the referral is not in writing, both the PASSPORT provider and the provider who will be performing the service should document the referral in the patient's medical record.

Authorization may be given by the PASSPORT provider or by the professional on call or covering for him or her. **PASSPORT authorization may not be provided by office staff.** However, office staff may be the means by which a provider communicates authorization.

When a PASSPORT provider authorizes a service, he or she will give you a PASSPORT authorization number to use on your claim form. It has been brought to Medicaid staff's attention that lists of PASSPORT numbers are being kept and used rather than getting the required authorization from the PASSPORT provider. If you use a PASSPORT provider's authorization number without actually receiving authorization and your claims are later reviewed in post-payment review, you will be required to return the payments received.

Recently Released Montana Medicaid Publications

With this issue of the "Montana Medicaid Claim Jumper" we will begin a new column to let you know of provider manuals and notices that were published in the last quarter. If you would like extra copies of these publications, please contact Provider Relations.

Date	Sent to	Topic
10/18/1999	Neuropsychologists and Psychologists	Psychologist services prior to 7/1/1999
11/1/1999	Mental Health Centers	Adult Therapeutic Home Leave
11/1/1999	Mental Health Providers	MHSP Eligibility Renewal
11/8/1999	Physicians, Mid-Level Practitioners, Lab and Radiology Providers	Lab and Radiology Services under Mental Health Services Plan
12/7/1999	Ambulatory Surgical Centers	2000 Medicare CPT codes
12/7/1999	All Montana Medicaid Providers	Recipients eligible for QMB only
12/7/1999	Mental Health Providers	MPQHF Prior Authorization forms
12/21/1999	Dentists and Denturists	New Coding System
January 2000	Durable Medical Equipment Providers	2000 HCPCS codes

Electronic Funds Transfer and Remittance Advice Available

Electronic Funds Transfer (EFT) is available to Montana Medicaid providers. In order to participate in EFT you must complete the direct deposit sign-up form (Standard Form 1199A) at your bank. **If you have more than one provider number, you must complete one form for each number.**

Upon receipt of your completed form, the Medicaid Direct Deposit Manager will start testing of electronic transfer for your Medicaid payments. Allow five to six weeks for normal testing. If the testing is not successful, the Direct Deposit Manager will work with you or your bank to resolve the problem. As soon as testing confirms payments to your account, you will begin receiving all Medicaid payments through EFT.

You may also request to have your Remittance Advice generated electronically to you in ANSI format. You will then be able to manipulate the data for easier reconciliation and posting. You do not need to participate in EFT in order to receive an Electronic Remittance Advice.

If you have any questions or concerns regarding EFT or the Electronic Remittance Advice, please call the Direct Deposit Help Desk at 406-444-5283.

Important Info about Provider Status Changes

When you have a change in status, such as address or ownership, it is **vitally** important that you notify Consultec Provider Relations in writing immediately. For security purposes faxes are not accepted, as the provider's **original** signature is required on change notifications.

The Postal Service is not allowed by law to forward government issued warrants. Informing us **in advance** of your mailing address change will ensure your receipt of your warrant and remittance advice without unnecessary delay. If your physical address changes, we need to have a new W-9 form completed and sent to us along with your written notification.

For income tax reporting purposes, it is necessary for you to tell us **at least 30 days in advance** about a change in ownership that causes a change in your Tax Identification Number. If your Tax ID number changes, you will be required to complete a Montana Medicaid Provider Enrollment Form and be issued a new provider number that will report your reimbursements from Medicaid under your new Tax ID number.

Also, please let us know if your telephone number changes.

MONTANA MEDICAID

CONSULTEC

P.O. BOX 8000
HELENA, MT 59604

BULK RATE
U.S. POSTAGE
P A I D
Permit No. 151
Great Falls, MT

INFORMATION TELEPHONE NUMBERS

Provider Relations	1-800-624-3958 (Montana Providers) 1-406-442-1837 (Helena and Out-of-State Providers) 1-406-442-4402 (FAX)		
FAXBACK	1-800-714-0075	AUTOMATED VOICE RESPONSE	1-800-714-0060
Point-of-Sale Help Desk	1-800-365-4944	PASSPORT	1-800-480-6823
Direct Deposit	1-406-444-5283	HMO – BC/BS HMO – YCHP	1-800-447-8747 1-800-721-3057

ACE$
ACCELERATED CLAIMS ENTRY SOFTWARE

Successful Roll-Out

Consultec is proud to announce the successful roll-out of ACE$, a new Windows-based software package for submitting Medicaid claims electronically. Since Volume VII of the "Montana Medicaid Claim Jumper" was published in October 1999, we have sent ACE$ Version 1.0 to all providers who were using our old software, ASAP, as well as many providers new to electronic billing.

ACE$ Version 1.1 has recently been released. In this updated version, reporting capabilities have been enhanced. If you are currently using Version 1.0 and wish to upgrade, please contact our EMC Coordinators at 1-800-624-3958 (in-state toll-free) or 406-442-1837 (Helena and out-of-state providers).

If you are interested in submitting your claims electronically, please contact our EMC Coordinators at the phone numbers listed above. They will send you the software and are available to help you with installation of the product.

Helpful hints: If you are using ACE$ to bill HCFA-1500's, please be sure to put your Montana Medicaid provider number in the "Provider Number" field and leave the "Pay-to Provider" field blank. The "Pay-to Provider" field is **only** to be used by the **Medicaid HMO's** when submitting their encounter claims.

Slashes must be included when entering service dates. For example, when entering service date January 28, 2000, enter "01/28/2000." Make sure to use the forward slash, not the backward slash.